

DEPARTMENT OF THE ARMY
HEADQUARTERS, UNITED STATES ARMY MEDICAL COMMAND
2050 Worth Road
Fort Sam Houston, Texas 78234-6000

MEDCOM Circular
No. 40-7

2 August 2001

Expires 2 August 2003
Medical Services
ASTHMA OUTPATIENT FORMS

1. HISTORY. This issue publishes a revision of this publication. Because the publication has been extensively revised, the changed portions have not been highlighted.

2. PURPOSE.

a. This circular provides policy and implementing instructions of the asthma outpatient forms prescribed by this circular: U.S. Army Medical Command (MEDCOM) Form 701-R (Asthma Outpatient Documentation), MEDCOM Form 702-R (Asthma Master Problem List), MEDCOM Form 703-R (Asthma Action Plan), and MEDCOM Form 704-R (Asthma Education).

b. These forms will facilitate outpatient treatment record (OTR) documentation by cueing the practitioner to document key aspects in their assessment and treatment of asthma patients. A panel of expert consultants from the Army, Navy, Air Force, and Department of Veterans Affairs (VA) identified key aspects by thoroughly examining scientific evidence on asthma. This panel synthesized the evidence on treatment of asthma in the Department of Defense/VA Practice Guideline on the Treatment of Asthma. Key aspects were then transformed onto the forms named in paragraph a above and prescribed by this circular.

3. APPLICABILITY. This circular applies to all MEDCOM facilities that have been granted an exception to policy for use of the test forms (prescribed herein) to document care of asthma patients.

4. REFERENCES. AR 40-66, Medical Record Administration and Health Care Documentation, provides guidance on medical record documentation and is applicable.

5. EXPLANATION OF ABBREVIATIONS AND TERMS.

a. Abbreviations.

MEDCOM . . . U.S. Army Medical Command
OTR outpatient treatment record
SF standard form
VA Department of Veterans Affairs

b. Terms. See AR 40-66.

*This circular supersedes MEDCOM Circular 40-7, 2 August 1999.

6. RESPONSIBILITIES. See AR 40-66.

7. POLICY.

a. Personnel in military treatment facilities may use MEDCOM Forms 701-R, 702-R, 703-R, and 704-R for the period of the test (through 2 August 2003) or as directed by the MEDCOM.

b. The MEDCOM test forms prescribed by this circular, with the exception of the MEDCOM Form 702-R (Asthma Master Problem List), will be filed in the OTR with the standard form (SF) 600 (Health Record-Chronological Record of Medical Care) in reverse chronological order (most recent on top). MEDCOM Form 702-R will be filed in the OTR on the left hand side of the record under DA Form 5571 (Master Problem List), if it exists.

c. MEDCOM Form 701-R may be used in lieu of the SF 600 to document treatment only for asthma patients being treated on an outpatient basis.

d. All current requirements of AR 40-66, other than those addressed in this circular, remain in effect.

8. INSTRUCTIONS FOR USE OF THE ASTHMA OUTPATIENT FORMS. Note: All forms are authorized for local reproduction (that is, "R" forms) and are contained in appendix A of this circular. All forms are to be printed head to foot, except MEDCOM Form 703-R which is only one page.

a. MEDCOM Form 701-R.

(1) Purpose. The form may be used to document the treatment of patients with asthma.

(2) Preparation. This form has three sections. Section I, vital signs, is to be completed by ancillary staff. Section II, patient assessment, is to be completed by the patient. Section III, current medications; Section IV, physical assessment; and Section V, diagnosis and treatment plan are to be completed by the provider.

(3) Content. Section I includes documentation of height, weight, and vital signs. Section II includes demographic, symptom, asthma triggers, and current medication history. Sections III, IV, and V include check box and free-hand areas for documentation of the patient's medical history, physical assessment, diagnosis, and treatment plan.

b. MEDCOM Form 702-R.

(1) Purpose. The form may be used by any provider to document all significant inpatient and outpatient visits and therapeutic intervention events in the management of the patient with asthma. It will provide a quick overview of the patient's asthma history to all providers, eliminating the need to page through the chart in order to "piece" a history together.

(2) Preparation. The form is to be initiated on the first asthma visit and then updated at every subsequent visit by the asthma care provider.

(3) Content. This form has three parts. Part I, asthma event tracking, contains spaces for documentation of pertinent major events in an

asthma patient's history (for example, emergency room visits, inpatient admissions, intubations, etc.) so that these events can be easily retrievable at each asthma visit. Part II, triggers identified (for example, exercise, URIs, weather). Part III, asthma symptom severity tracking chart, provides a place to document the initial classification and progression (as applicable) of the patient's asthma disease as either mild intermittent, mild persistent, moderate persistent, and severe; medication tracking, documents the initial and subsequent medications being utilized to manage the patient's asthma.

c. MEDCOM Form 703-R.

(1) Purpose. The form may be used by any provider to document the patient's self-management plan agreed upon by the patient and the physician.

(2) Preparation. The form is to be completed and/or reviewed by the physician with the patient at every asthma visit. A copy of the form is to be given to the patient at the end of the outpatient visit.

(3) Content. This form has four sections: a health care provider notification information section and three asthma management sections defining that patient's self-management for green, yellow, and red zone asthma episodes.

d. MEDCOM Form 704-R.

(1) Purpose. The form may be used to document asthma education provided to the patient.

(2) Preparation. The form is to be completed by the individual providing the asthma education to the patient.

(3) Content. This form has two sections. In the demographic/history section, the educator assesses the educational needs of the patient as indicated by the severity of the patient's asthma. The education section lists the teaching objectives and the action taken regarding these objectives. Teaching objectives relate to asthma pathophysiology, triggers, medications, spacer use, and peak flow meter use and their relationship to the overall goal of asthma education: patient self-management.

APPENDIX A

Appendix A contains the following "R" forms (authorized for local reproduction).

MEDCOM Form 701-R (Asthma Outpatient Documentation)

MEDCOM Form 702-R (Asthma Master Problem List)

MEDCOM Form 703-R (Asthma Action Plan)

MEDCOM Form 704-R (Asthma Education)

<input type="checkbox"/> Initial visit <input type="checkbox"/> Follow up visit	ASTHMA OUTPATIENT DOCUMENTATION For use of this form see MEDCOM Cir 40-7	DATE _____		
SECTION I - VITAL SIGNS (To be completed by Ancillary Support Staff)				
Time: _____ Temp: _____ Pulse: _____ Resp: _____ BP: _____ Ht: _____ Wt: _____ Age: _____ Do you use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No Want to quit? <input type="checkbox"/> Yes <input type="checkbox"/> No Cessation material provided? <input type="checkbox"/> Yes <input type="checkbox"/> No Allergy: _____ Ht Percentile (If <18) _____ O ₂ Sat: _____ Peak Flow: _____ FEV ₁ : _____				
SECTION II - PATIENT ASSESSMENT (To be completed by Patient/ Reviewed by Provider)				
ASTHMA SEVERITY ASSESSMENT				
RATE THE OCCURRENCE OF THE FOLLOWING	MILD INTERMITTENT	MILD PERSISTENT	MODERATE PERSISTENT	SEVERE PERSISTENT
Daytime wheezing, shortness of breath	<input type="checkbox"/> 2 times per week or less	<input type="checkbox"/> Greater than 2 times per week	<input type="checkbox"/> Daily	<input type="checkbox"/> Continually
Night-time wheezing, shortness of breath	<input type="checkbox"/> 2 times per month or less	<input type="checkbox"/> Greater than 2 times per month	<input type="checkbox"/> Greater than 1 time per week	<input type="checkbox"/> Frequent
How often are your physical activities limited by asthma	<input type="checkbox"/> 2 times per week or less	<input type="checkbox"/> Greater than 2 times per week	<input type="checkbox"/> Greater than 2 times per week	<input type="checkbox"/> Frequent
Daily use of albuterol or "rescue drugs"	<input type="checkbox"/> Less than 1 time per week or less than 3 times per month	<input type="checkbox"/> 1 time per week or more	<input type="checkbox"/> Daily use	<input type="checkbox"/> Frequent
Rate your current peak flow in relation to your best peak flow	<input type="checkbox"/> Greater than 80% of predicted	<input type="checkbox"/> Greater than 80% of predicted	<input type="checkbox"/> Between 60% and 80% of predicted	<input type="checkbox"/> Less than 60% of predicted
In the past month, how many days have you missed work, school, or daycare due to limitation of your physical activities because of your asthma symptoms? _____				
SECTION III - CURRENT MEDICATIONS				
	NUMBER OF PUFFS	HOW OFTEN	DATE LAST USED	DON'T USE
Albuterol - - - - -	_____	_____	_____	_____
Inhaled Steroid - - - - -	_____	_____	_____	_____
Cromolyn, Nedocromil - - - - -	_____	_____	_____	_____
Salmeterol - - - - -	_____	_____	_____	_____
Other - - - - -	_____	_____	_____	_____
Do you have an Asthma Action Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you use a peak flow meter? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you use a spacer or holding chamber? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you using steroid pills? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you use a nebulizer? <input type="checkbox"/> Yes <input type="checkbox"/> No				
PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)		_____ (Patient's Signature)		

SECTION IV - PHYSICAL ASSESSMENT (To be completed by Provider)

☐ Height compared against growth chart (*< 18 years - high dose steroids*).

Assess HEENT, Lungs, and CV:

SECTION V - DIAGNOSIS AND TREATMENT PLAN

SYMPTOMS	MEDICATIONS	ACTUAL MEDICATION AND DOSE
<input type="checkbox"/> Mild Intermittent	<input type="checkbox"/> Inhaled short-acting beta-agonist PRN <input type="checkbox"/> Other	
<input type="checkbox"/> Mild Persistent	<input type="checkbox"/> Inhaled short-acting beta-agonist PRN AND <input type="checkbox"/> Low-dose inhaled corticosteroid OR <input type="checkbox"/> Cromolyn/Nedocromil/Leukotriene modifier	
<input type="checkbox"/> Moderate Persistent	<input type="checkbox"/> Inhaled short-acting beta-agonist PRN AND <input type="checkbox"/> Inhaled low/medium dose corticosteroid <input type="checkbox"/> Inhaled long-acting beta-agonist <input type="checkbox"/> Other	
<input type="checkbox"/> Severe Persistent	<input type="checkbox"/> Inhaled short-acting beta-agonist PRN AND <input type="checkbox"/> Inhaled high dose corticosteroid <input type="checkbox"/> Inhaled long-acting beta-agonist <input type="checkbox"/> Other (oral steroids)	

PLAN: Immunizations: ☐ Flu ☐ Pneumovax

Other medication/treatment given:

REFERRALS: ☐ Consider bone densitometry (*> 18 - high dose corticosteroids*) ☐ Asthma education
☐ Tobacco cessation program ☐ Specialty care

Written Action Plan given to patient/copy placed in chart ☐ Yes ☐ No

Asthma Master Problem List initiated/reviewed/updated ☐ Yes ☐ No

FOLLOW-UP:

(Provider's Name)

(Provider's Signature)

For use of this form see MEDCOM Cir 40-7

a. Date of Onset:	(Enter dates in columns below for items b thru k)				Date of Initial Spirometry:			
b. Skin testing								
c. Emergency room visits/Acute Care:								
d. Admissions:								
e. Intubations:								
f. Spirometry:								
g. Formal asthma education:								
h. Oral steroids:								
i. Six-month bone density test:								
j. Other (Specify):								
k. Other (Specify):								

<input type="checkbox"/> Exercise	<input type="checkbox"/> Weather/Dry Air	<input type="checkbox"/> Pollen	<input type="checkbox"/> Mold
<input type="checkbox"/> URIs	<input type="checkbox"/> Dust	<input type="checkbox"/> Smoke/Fumes	<input type="checkbox"/> Roaches
<input type="checkbox"/> Weather/Cold Air	<input type="checkbox"/> Stress	<input type="checkbox"/> Pets	<input type="checkbox"/> Other (Specify): _____

(Enter date at top of the column and place an X in the column to indicate frequency of asthma symptoms.)

[illegible][illegible][illegible][illegible][illegible]

NOTES

TABLE A: Stepcare Approach for Prescribing Asthma Medications Based on Severity

SEVERITY LEVEL	SIGNS/ SYMPTOMS	NOCTURNAL SYMPTOMS	LUNG FUNCTION	DRUG THERAPY
Mild Intermittent	<ul style="list-style-type: none"> - Symptoms \leq 2 times/week - Exacerbations brief - Asymptomatic/normal PEF between exacerbations 	<ul style="list-style-type: none"> - \leq 2 times/month 	<ul style="list-style-type: none"> - FEV₁, or PEF $>$ 80% predicted - PEF variability $<$ 20% 	<u>Quick Relief</u> <ul style="list-style-type: none"> - Inhaled short-acting beta-agonist PRN <u>Long Term Control</u> <ul style="list-style-type: none"> - Usually no daily medication needed
Mild Persistent	<ul style="list-style-type: none"> - Symptoms $>$ 2 times/week but $<$ 1 time/day - Exacerbations can affect activity 	<ul style="list-style-type: none"> - $>$ 2 times/month 	<ul style="list-style-type: none"> - FEV₁, or PEF \geq 80% predicted - PEF variability 20-30% 	<u>Quick Relief</u> <ul style="list-style-type: none"> - Inhaled short-acting beta-agonist PRN <u>Long-Term Control</u> <ul style="list-style-type: none"> - Inhaled corticosteroid (LOW dose) - May also consider theophylline SR, leukotriene modifier, cromolyn or nedocromil - For patients with ASA sensitive asthma, consider using leukotriene modifiers
Moderate Persistent	<ul style="list-style-type: none"> - Symptoms daily - Exacerbations $>$ 2 times/week and affect activity 	<ul style="list-style-type: none"> - $>$ 1 time/week 	<ul style="list-style-type: none"> - FEV₁, or PEF \geq 60% $<$ 80% predicted - PEF variability $>$ 30% 	<u>Quick Relief</u> <ul style="list-style-type: none"> - Inhaled short-acting beta-agonist PRN <u>Long-Term Control</u> <ul style="list-style-type: none"> - Inhaled corticosteroid (MEDIUM dose) OR - Inhaled corticosteroid (LOW-MEDIUM dose) & inhaled long-acting beta-agonist OR - Inhaled corticosteroid (LOW-MEDIUM dose) & theophylline - Consider referral
Severe Persistent	<ul style="list-style-type: none"> - Symptoms continuous - Limited physical activity - Exacerbations frequent 	<ul style="list-style-type: none"> - Frequent 	<ul style="list-style-type: none"> - FEV₁, or PEF $<$ 60% predicted - PEF variability $>$ 30% 	<u>Quick Relief</u> <ul style="list-style-type: none"> - Inhaled short-acting beta-agonist PRN <u>Long-Term Control</u> <ul style="list-style-type: none"> - Inhaled corticosteroid (HIGH dose) & inhaled long-acting beta-agonist OR - Inhaled corticosteroid (HIGH dose) & theophylline - Oral corticosteroid may be indicated - Consider referral

ASTHMA ACTION PLAN For use of this form see MEDCOM Cir 40-7			
GREEN ZONE: Doing Well		Take these Long-Term-Control Medicines each day (Includes an anti-inflammatory)	
<input type="radio"/> No cough, wheeze, chest tightness, or shortness of breath during the day or night.		Medicine	How much to take
<input type="radio"/> Can do usual activities			When to take it
And if a peak flow meter is used, peak flow more than _____			
(80% or more of my best peak flow)			
My best peak flow is: _____			
Before exercise - - - - -		<input type="checkbox"/> 2 or <input type="checkbox"/> 4 puffs, 5 to 60 minutes before exercise	
YELLOW ZONE: Asthma is Getting Worse		1st → Add: Quick-Relief Medicine-and keep taking your GREEN ZONE medicine	
<input type="radio"/> Cough, wheeze, chest tightness, or shortness of breath or		(short acting beta-agonist) <input type="checkbox"/> 2 or <input type="checkbox"/> 4 puffs, every 20 minutes for up to 1 hour	
<input type="radio"/> Waking at night due to asthma, or		<input type="checkbox"/> Nebulizer, once	
<input type="radio"/> Can do some, but not all, usual activities			
- OR -		If symptoms (and peak flow, if used) return to GREEN ZONE after 1 hr of above treatment:	
Peak flow: _____ to _____		<input type="checkbox"/> Take the quick-relief medicine every 4 hours for 1 to 2 days.	
(60% - 80% of my best peak flow)		<input type="checkbox"/> Double the dose of your inhaled steroid for _____ (7-10) days.	
		- OR -	
		If symptoms (and peak flow, if used) do not return to GREEN ZONE after 1 hour of above treatment:	
		<input type="checkbox"/> Take _____ <input type="checkbox"/> 2 or <input type="checkbox"/> 4 puffs or <input type="checkbox"/> Nebulizer	
		(short acting beta-agonist)	
		<input type="checkbox"/> Add _____ mg. per day for _____ (3-10) days.	
		(oral steroid)	
		<input type="checkbox"/> Call your Healthcare Provider within _____ hours after taking the oral steroid.	
RED ZONE: Medical Alert!		Take this medicine:	
<input type="radio"/> Very short of breath, or		<input type="checkbox"/> _____ <input type="checkbox"/> 4 or <input type="checkbox"/> 6 puffs or <input type="checkbox"/> Nebulizer	
<input type="radio"/> Quick-relief medicines have not helped, or		(short acting beta-agonist)	
<input type="radio"/> Cannot do usual activities, or		<input type="checkbox"/> _____ mg.	
<input type="radio"/> Symptoms are same or get worse after 24 hours in Yellow Zone		(oral steroid)	
- OR -		Then call your Healthcare Provider - NOW! Go to the hospital or call for an ambulance if:	
Peak flow is less than: _____		<input type="checkbox"/> You are still in the red zone after 15 minutes and using your nebulizer AND	
(< 60% of my best peak flow)		<input type="checkbox"/> You have not reached your Healthcare Provider	
DANGER SIGNS!		!!!! → Take <input type="checkbox"/> 4 or <input type="checkbox"/> 6 puffs of your quick-relief medicine AND	
<input type="radio"/> Trouble walking/talking due to shortness of breath		Go to the hospital or call for an ambulance	
<input type="radio"/> Lips or fingernails are blue		NOW!	

PATIENT IDENTIFICATION	HEALTHCARE PROVIDER'S NAME:	
	HEALTHCARE PROVIDER'S PHONE	
	HOSPITAL/EMERGENCY ROOM PHONE	
	I have read, understand, and have been given a copy of this Action Plan.	
	(Patient's Signature)	(Date)

MEDCOM FORM 703-R (TEST) (MCHO) JUL 99

MC V1.00

ASTHMA EDUCATION

For use of this form see MEDCOM Cir 40-7

DATE _____

☐ Initial Visit☐ Follow-Up Evaluation

If follow-up, date of initial evaluation: _____

Name _____ Age _____ Age at time of asthma diagnosis _____

Sponsors' SSN _____ Relation to sponsor _____

Clinic which provides asthma care: _____

Healthcare Provider who provides asthma care: _____

How were you referred to this clinic? ☐ ED ☐ INPT ☐ OTHER _____

Date of most recent asthma attack? _____

How would you classify your asthma symptoms during the past 2 weeks?

☐ None☐ Mild/transient☐ Moderate/frequent☐ Severe/continuous

How many days have you missed school or work because of asthma over the past year? _____ (estimate number)

How many days have your parents/family members missed work because of your asthma over the past year?

Active duty parent/family member(s) _____ non-active duty parent/family member(s) _____ (estimate number)

Is there a lot of stress in your family currently as a result of asthma? ☐ Yes ☐ NoDo you feel that you now have the knowledge and confidence to manage asthma? ☐ Yes ☐ No

Please rate your satisfaction with your current asthma care. (Circle a number)

Not Satisfied at all

0 1 2 3 4 5

Very Satisfied

How many times TOTAL have you been hospitalized for asthma? _____ # hospitalizations (please give your best estimate)

How many times were you hospitalized for asthma in the past year? _____ # hospitalizations (# days total / year)

How many times were you hospitalized for asthma in the past month? _____ # hospitalizations (# days total / month)

How many times TOTAL have you been to the emergency department for asthma? _____ # visits (please give your best estimate)

How many times did you go to the emergency department for asthma in the past year? _____ # visits/year

How many times did you go to the emergency department for asthma in the past month? _____ # visits/month

How many times TOTAL have you made an urgent visit to the clinic for asthma? _____ # visits

How many times did you make an unscheduled visit to the clinic for asthma in the past year? _____ # visits/year

How many times did you make an unscheduled visit to the clinic for asthma in the past month? _____ # visits/month

Current **asthma** medications

Dosage prescribed:

Dosage Patient is actually using:

1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

PEF today _____ % personal best _____

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)

(Patient's Signature)

PART A - PATHOPHYSIOLOGY	YES	NO	ACTION TAKEN
Understands that asthma is a chronic disease			
Understands bronchospasm, excess mucous production and inflammation			
Understands that low blood oxygen during an asthma attack can lead to death			
PART B - TRIGGERS	YES	NO	ACTION TAKEN
Patient smokes			
Patient lives in a house with smokers			
Patient has been previously skin tested			
Patient was counseled about specific environmental avoidance measures or control			
Avoidance or control measures have been taken.			
Understands avoidance of NSAIDs, B-blockers			
Received flu vaccine in past year			
PART C - MEDICATIONS	YES	NO	ACTION TAKEN
Using medications as prescribed (see reverse)			
Patient understands use of "911" rescue medications vs daily maintenance medication			
Uses spacer and rinses mouth if on inhaled steroids			
PART D - MDI TECHNIQUE/ DPI TECHNIQUE	YES	NO	ACTION TAKEN
Patient able to assemble MDI/spacer or prepares DPI correctly			
Shakes canister (MDI)			
Spacer use encouraged. If not, uses MDI at lips 2 fingerbreadths from mouth			
Begins inhalation at the end of a normal expiration			
Activates MDI canister within 0.5-1.0 seconds of inhaling			
Breaths in slowly for MDI or forcefully for DPI			
Holds breath 5 - 10 seconds			
PART E - PEAK FLOW METER USE	YES	NO	ACTION TAKEN
Patient has a peak flow meter			
Knows personal best			
Knows green/yellow/red zone readings			
Checks and records PEFr appropriately (for mod-severe asthma - q AM, for mild asthma - bid x 2 wks q 6months, for any exacerbation - q4hrs)			
Patient seen by continuity physician on a regular basis			
Patient has a written action plan			
Patient exhibits compliance problems (medically or psychologically)			
PART F - GOALS OF ASTHMA MANAGEMENT	YES	NO	ACTION TAKEN
Are there any limitations of activity dues to asthma?			
Uses rescue meds _____ times per week. greater than 2 x/week?			
Recognizes asthma exacerbations and begins treatment appropriately			
Has nocturnal symptoms			
Knows personal best peak flow rate (PEFR)			
PEFR remains > 80% personal best			
Experience significant side effects of asthma medications			
GOALS OF ASTHMA MANAGEMENT MET			
Date Followup visit scheduled for _____			

The proponent of this publication is the Office of the Assistant Chief of Staff for Health Policy and Services. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) to Commander, U.S. Army Medical Command, ATTN: MCHO-Q, 2050 Worth Road, Fort Sam Houston, TX 78234-6026.

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